Adopt Ins 3800, to read as follows:

CHAPTER Ins 3800 MEDICAL PROFESSIONAL LIABILITY INSURANCE

Statutory Authority: RSA 400-A;15, I.; RSA 412:43; RSA 519-B:12 II.

PART Ins 3801 MANDATORY REPORTING OF DETAILED CLAIM INFORMATION

Ins 3801.01 Purpose. This purpose of this chapter is to identify the rules and guidelines to be used to report detailed claim information applicable to medical professional liability insurance.

Ins 3801.02 Scope. This chapter shall apply to all insurers writing medical professional liability insurance in this state.

Ins 3801.03 Definitions.

(a) "Act or omission code (cause of loss)" means the 3-digit code provided by the insurance carrier, that identifies the type of loss category related to:

(1) Diagnosis;

(2) Anesthesia;

(3) Surgery;

(4) Medication;

(5) Intravenous and blood products;

(6) Obstetrics;

(7) Monitoring;

(8) Biomedical;

(9) Equipment/Product; and

(10) Miscellaneous.

(b) "Claim" means a request for indemnification submitted by a health care provider pursuant to a medical professional liability insurance policy for which an insurer has established a loss or loss adjustment expense reserve amount at any point in time.

(c) "Claim disposition code" means the 2-digit code identifying the final method of claim disposition.

(d) "Claim field identification" means a unique code assigned to each claim by the insurer.

(e) Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on behalf of the insured.

(f) "Commissioner" means the insurance commissioner of the state of New Hampshire.

(g) "Common statistical base classification code" means the ISO 5-digit code used to identify professional liability risk classifications.

(h) "Companion claim" means a separate claim for each named defendant that is covered under the policy, whether or not they are the named insured on the policy or covered employees or agents of a corporation, association or trust.

(i) "Court code" means the 2-digit code identifying the result of court proceedings.

(j) "Date of payment or closure" means the date on which the insurer closed the claim.

(k) "Health care provider" means:

(1) In the case of a natural person, a person, licensed or approved by the state to provide health care or professional services, including, but not limited to:

a. Physician;

b. Surgeon;

c. Osteopath;

d. Podiatrist;

e. Chiropractor;

f. Dentist;

g. Dental hygienist;

h. Registered pharmacist;

i. Registered professional nurse;

j. Licensed practical nurse;

k. Nurse midwife;

l. Advanced registered optometrist;

m. Physical therapist;

n. Physiotherapist;

o. Physician's assistant;

p. Paramedic; or

q. Psychologist.

(2) In the case of an institution:

a. Hospital;

b. Nursing home;

c. Health maintenance organization;

d. Ambulance or other corporation;

e. Facility or entity licensed by the state to provide health care services; or

f. An officer, employee or agent of any such person or institution acting in the course and scope of his employment; and

(3) Where the context so permits, both persons and institutions as listed in (1) or (2) above.

(l) "Incurred loss" means the sum of dollars paid and dollars established to make future payments to indemnify a claimant on behalf of the insured.

(m) "Insurance Services Office (ISO)" means the property and casualty, non-profit insurance advisory entity that assists insurers in the collection of statistical information and ratemaking-related activities.

(n) "Insured" means the policyholder and any named defendants covered under a medical professional liability insurance policy.

(o) "Insurer" means every:

(1) Insurance company authorized to transact insurance business in this state;

(2) Unauthorized insurance company transacting business pursuant to RSA 406-B;

(3) Risk retention group;

(4) Insurance company issuing insurance to or through a purchasing group;

(5) Captive insurance company;

(6) Self-insured person or entity; and

(7) Other person providing insurance in this state.

(p) "License number" means the number assigned by the New Hampshire board of medicine or the federal identification number.

(q) "Loss adjustment expense" means the dollars expended to defend, manage, or otherwise process a claim on behalf of the insured health care provider.

(r) "Medical professional liability insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of the negligence or malpractice in rendering professional service by any health care provider.

(s) "NAIC" means the National Association of Insurance Commissioners.

(t) "NAIC group and company code" means the NAIC assigned 9-digit code beginning with the group 4-digit code followed by the company 5-digit code or the assigned NAIC alien number.

(u) "National Practitioner's Data Bank" means the data maintained by the U.S. Department of Health and Human Services and established by the Health Care Quality Improvement Act of 1986, Title IV of Public Law 99-660 as amended.

(v) "Open claim" means a claim that has yet to be settled, or otherwise disposed of, where the insurer expects to make future indemnity and expense payments on behalf of the insured.

(w) "Open claim ID number" means the original identification number used when the claim was previously filed with the department.

(x) "Paid loss" means the dollars paid by an insurer to the claimant on behalf of the insured.

(y) "Panel code" means the 2-digit code identifying where the claim is in the screening panel process.

(z) "Practice code" means the 2-digit code if the insured is a physician or other medical professional.

(aa) "Profession code" means the 2-digit code identifying the medical specialty practiced by the health care provider.

(ab) "Reserve" means the dollar value established by the insurer as their best estimate of the dollar amount needed to cover future loss and loss adjustment expense payments.

(ac) "Settlement code" means the 2-digit code used to identify when in the legal process the claim has been settled.

(ad) "Severity of injury code" means the 2-digit code that identifies the relative degree or severity of injury, covering a range from "emotional only" to "death."

(ae) "Specialty code" means the 5-digit code established by the ISO to define a common statistical base classification code used for underwriting.

Ins 3801.04 Detailed Reporting Requirements.

(a) As a condition of doing business in this state, each insurer providing medical professional liability insurance coverage to a New Hampshire health care provider, and every health care provider who maintains professional liability coverage through a plan of self insurance, shall submit to the commissioner a report of all open and/or closed claims and companion claims made against any New Hampshire insureds during the preceding 3 month period.

(b) Every report shall contain the following detailed information:

(1) A summary listing the individual claim reports included with the particular submission;

(2) A separate form titled "Medical Professional Liability Insurance Claim Report" filed for each individual claim newly opened, modified or closed during the previous 3 month period, and for which the following mandatory fields are completed:

a. When reporting an open claim:

1. Name of insurer (Item 1a);

2. Claim file identification (Item 1b);
3. NAIC group and company code (Item 1c), if applicable;
4. Date of injury (Item 2a);
5. Date reported to insurer (Item 2b);
6. Date reopened (Item 2c);
7. Original claim ID number (Item 2d);
8. License number (Item 3);
9. Insured's name (Item 3a);
10. Insured's age (Item 3b);
11. Address of insured (Items 3c, 3d, 3e);
12. License number of health professional (Item 4);
13. Name of health professional (Item 4a);
14. Address of health professional (Items 4b, 4c, 4d, 4e);
15. Telephone number of health Professional (Item 4f);
16. Name of person (alleged cause) (Item 5a);
17. Address of person (alleged cause) (Item 5b, 5c, 5d, 5e);
18. Telephone number of person (alleged cause) (Item 5f);
19. Profession code of the insured (Item 6a);
20. Specialty code (Item 6b);
21. Practice code (Item 6c);
22. Place of occurrence code (Items 7a, 7b, 7c, 7d)
23. Name of institution, if injury occurred in institution (Item 8a);
24. Location of injury code (Item 8b);
25. Injured person's name (Item 9a);
26. Injured person's age (Item 9b);
27. Injured person's sex (Item 9c); and
28. Injured person's date of birth (Item 9d);
29. Injured person's address (Items 9e, 97, 9g, 9h); and

30. Injured person's telephone number (Item 9i);

31. Person instituting the claim if injured party is deceased or a minor (Item 10a);

32. Address of person instituting claim (Item 10b, 10c, 10d, 10e)

33. Telephone number of person instituting claim (Item 10f);

34. Total defendants involved in claim (Item 11a);

35. Derivative claim code (Item 11b);

36. Amount of reserve for indemnity if outstanding (Item 12a);

37. Amount of reserve for expense if still outstanding (Item 12b);

38. Plaintiff attorney's name (Item 13a);

39. Plaintiff attorney's address (Items 13b, 13c, 13d); and

40. Plaintiff attorney's telephone number (Item 13e);

41. Nature and substance of claim (Item 14);

42. Act or omission codes (Item 14a);

43. Severity of injury code (Item 15); and

44. Companion claim file identification (Item 16).

b. When a claim is reported and closed:

1. Date of payment or closure (Item 17);

2. Claim disposition code (Item 18);

3. Settlement code (Item 19);

4. Court code (Item 20**a**);

5. Name of Court (Item 20b);

6. Docket Number (Item 20c);

7. Date Suit Filed (Item 20d); and

8. If applicable:

(i) Indemnity pay (Item 21), including:

i. Economic damages (Item 21a);

ii. Non-economic damages (Item 21b); and

iii. Punitive damages (Item 21c);

(ii) Other indemnity paid (Item 22);

(iii) Indemnity paid by all parties (Item 23);

(iv) Loss adjustment expense paid to defense counsel (Item 24);

(v) All other allocated loss adjustment expense paid (Item 25);

(vi) Injured person's incurred medical expense (Item 26);

(vii) Injured person's anticipated future medical expense (Item 27);

(viii) Injured person's incurred wage loss (Item 28);

(ix) Injured person's anticipated future wage loss (Item 29);

(x) Injured person's other expenses (Item 30); and

(xi) Total amount allocated for future period pay (Item 31).

c. Name, telephone number and address of person to contact about the medical professional liability insurance claim report.

d. Name of person responsible for preparing the medical professional liability insurance claim report.

Ins 3801.05 Report Dates. The report shall be sent to the department no later than 10 days following the close of each quarter or on or before January 10th, April 10th, July 10th, and October 10th.

Ins 3801.06 Penalty. Failure to file a completed report in accordance with the provisions outlined in this rule shall result in the application of the penalty provisions of RSA 412:40.

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